THE COACHING ROLE-BEYOND HEALING AND CURING: PHYSICIAN ASSISTED DEATH IS NOT INCOMPATIBLE WITH A PHYSICIAN'S ROLE

by

Vivian V. Altiery De Jesus

A thesis submitted to Johns Hopkins University in Conformity with the requirements for the degree of Masters of Bioethics.

Baltimore, Maryland

April 2020

ABSTRACT

Physician assisted death (PAD) is a controversial topic in bioethics. Although PAD is legal in 9 States and Washington D.C. as of 2019, the American Medical Association (AMA) Code of Ethics states that PAD is "fundamentally incompatible with the physician's healer role". No further reasoning is provided nor an explanation of how exactly PAD is incompatible with the physician's healer role. I discuss conceptions of physician's healing role from the literature, noting that healing is often mistakenly interchanged with curing. Since PAD is certainly not curing, conflating healing and curing inclines one to conclude that PAD is incompatible with the physician's role as healer".

Nonetheless, even under the explicit distinction between curing and healing, PAD is sometimes but not always an instance of healing. However, the physician's role is not constrained to the curing-healing dichotomy. Therefore, in this article I also consider whether non-healing PAD could still be compatible with the physician's healer role. Lastly, I propose that we should conceive of physicians as *coaching* patients, a role that includes curing and healing, as well as other roles. I argue that PAD is compatible with the physician's role as coach. Thus, contrary to the AMA's position, PAD can be compatible with physician's role.

Primary Reader: Anne Barnhill, Ph.D.

Secondary Reader: Travis Rieder, Ph.D.

ACKNOWLEDGMENT

My deepest gratitude and respect to both of my thesis mentors. My first reader-mentor, Dr. Anne Barnhill, guided me to shape and re-shape my thesis. I am grateful for our long hours of back and forth discussion, the extensive arguments mapping with plausible rebuttals, for every "*aha*" moment we had in the process. My second reader-mentor, Dr. Travis Rieder, guided me from my first encyclopedic outline through my first draft. I am grateful for all the feedback from content to structure, for every "*not a book*" warning. I thank you both for your meticulous and rigorous ***coaching*** during this endeavor. For sharing your knowledge, passion and dedication to bioethics and your students.

I want to thank the Agraphia Team, an interesting and challenging group that I had the honor to being part of. Hunter Jackson Smith, M.D, Emily Farmer, Christen Paradissis, Margot Kelly-Hedrick and Cami Docchio; thank you for your constructive criticism.

I want to also thank Sr. Academic Program Coordinator, Penny L. White, who showed her support and guidance throughout the administrative process. Her advice and counseling are invaluable. My gratitude to the Berman Institute (BI) of Bioethics. The BI was more than just a learning place. Thank you for all the intellectual, but most importantly, humanistic experience.

Lastly, I want to thank my family, without them, this would all be but a dream. My mother, Vivian De Jesús, whose unconditional love, support, patience and wit have shaped who I am today. My father, Julio Altiery, for his endless humor and tenderness. My siblings Vivian Alejandra Altiery De Jesús and Julio Ángel Altiery De Jesús, for their eternal support, honesty, and formidable debates.

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

Physician assisted death (PAD) is a controversial topic in bioethics and law. PAD, also known as physician assisted suicide (PAS), is "when [a] physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act"[1]. Currently in the United States, PAD is legal in nine states and Washington D.C. either by statute or mandated by Court ruling[2,3]. In States where PAD is legal, only patients who meet specific, rigorous criteria, such as terminally ill[a] diagnosis and patient's capacity to provide informed consent are allowed to participate in PAD. The ethical analysis in this paper concerns PAD in patients who are actively dying[b] and terminally ill who meet those requirements found in the United States legislation.

Proponents of physician assisted death argue that PAD respects the patient's autonomy by allowing control during the dying process, as well as minimizing suffering which can threaten the patient's sense of wholeness[5-8]. The Death with Dignity National Center, a PAD advocacy group, identifies the following benefits of PAD for terminally ill patients: [1] "freedom to control their own ending", [2] "[allows the patient] to die a peaceful death at a time and place of [their] choosing", [3] "provides invaluable peace of mind" [4] "[allowed] to die at home", [5] "family members, too, derived peace of mind [since] they will not have to helplessly endure watching a loved one die a horrible death" [9].

[a] The terminally ill concept is applied to a patient suffering from a lethal and progressive disease which is expected to die in a relatively short period[4] .

[b] The actively dying is defined as "[a] rapid and irreversible organ system disintegration"[4].

Despite the potential benefits for terminally ill patients, the American Medical Association opposes PAD in its Code of Ethics, Opinion E5.7[c] [10,11]:

> "Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
>
> It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.
>
> Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
>
> (a) Should not abandon a patient once it is determined that cure is impossible.
>
> (b) Must respect patient autonomy.
>
> (c) Must provide good communication and emotional support.
>
> (d) Must provide appropriate comfort care and adequate pain control".

In this opinion, the AMA offers four objections to PAD : [1] "PAS causes more harm than good", [2] "is fundamental incompatibility with the physician's healer role", [3] "would be difficult to control" and lastly, [4] "it will expose society to high and serious risks" [1]. This paper addresses the AMA's claim that PAD is incompatible with the physician's role as healer—perhaps the most fundamental of the objections raised by the AMA. This paper argues that PAD can be compatible with the physician's role. The broader aim of this paper is to promote a more open and objective dialogue about PAD since it is my perception that physicians could play an essential role in this process.

[c] The Code provides the "proponents perspective" through Opinion 1.1.7. However, compare to Opinion E-5.7 (PAD's opponents' perspective), it does not directly address PAD and the language is ambiguous, confusing and less straightforward. Due to the lack of specificity and helpfulness, Opinion 1.1.7 will not be address in this paper.

This paper proceeds as follows: the next section provides background on PAD. In Section 1, I consider, **h*ow should we understand the physician's role as healer?*** I discuss conceptions of physician's healing role from the literature and consider the contrast between healing and curing recognized by some scholars. In Section 2, I discuss ***could PAD be considered healing under certain circumstances?*** I argue that PAD is sometimes an instance of healing, but not always. Thus, an ethical defense of PAD must explain how PAD is compatible with the physician's role as healer even when the PAD is not healing. This is the topic I take up in Section 3, where I consider ***could non-healing PAD still be compatible with the physician's healer role?*** In section 4, I introduce ***the physician's role as coach***. The role of a physician goes beyond curing patients or healing them. I propose that we should conceive of physicians as coaching patients, a role that includes curing and healing, as well as other roles. I argue that PAD is compatible with the physician's role as coach. Finally, in Section 5, I consider objections to and clarification of the physician's role as coach.

BACKGROUND

The prohibition on physician-assisted death dates back to one of the earliest codes in the medical profession: the Hippocratic Oath. The oath states that "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect"[12]. The 20th century, however, approved PAD through legalization in a few countries such as Belgium and the Netherlands. In the United States, the Supreme Court ruled in Washington v. Glucksberg that PAD should be decided in the "laboratory of the states" [13,14]. PAD was legalized in Oregon in 1995, followed by Washington (2008), Vermont (2013), California (2015), Colorado (2016), District of Columbia (2017), Hawaii (2018) and New Jersey (2019)[15]. PAD is currently a highly debated topic in State legislatures.

Although each State may have their own regulation, I will take the Washington Death With Dignity Act (WDWD) as an example of a PAD law [16]. The Act applies to terminally ill adults who have less than six months to live and are Washington residents. The Act requires that patients make an oral request to the prescribing physician, the patient then meets with a consulting physician, and if required by either physician the patient must meet with a psychiatrist. After meeting with the consulting physician, a written request must be made to the prescribing physician with a minimum of 15 days apart from the oral request. The request must also be reviewed by a social worker, who must have the written request 48hr before the prescription can be written. The patient must also self-administer the medication in a non-public space.

The WDWD differs strikingly from the Netherlands' PAD regulation. The Netherlands permitted PAD and euthanasia[d], for over 30 years prior to the legalization in 2002[15]. In the Netherlands, PAD and euthanasia are available to patients who are not terminally ill, the pediatric population, and those without capacity. A few worrying examples from the Netherlands includes applying PAD and euthanasia as a "treatment" for dementia, old age, neonates and even for reason such as 'I am through with this'[17-22]. Recently, a government proposal in the Netherlands brought into discussion whether a terminal care provider (whom is not necessarily related to the healthcare field) should have the authority to override a denied request for PAD or euthanasia by a physician after medical evaluation[22].

It is unlikely that the United States will follow the Netherland's example on PAD anytime soon. Studies on PAD usage in Oregon have found that most patients who used PAD were Caucasian or Asian with at least some college education[23,24], and another study found that unmarried and more highly educated individuals were more likely to request PAD[25]. In other words, the data shows that after 20 years of PAD in Oregon, most of the participants do not belong to vulnerable populations. Restrictions on PAD have remained unchanged since the DWDA was passed in Oregon twenty years ago: patients still must have a terminal condition and be adult residents of the State with full capacity.

[d] Euthanasia is defined by the AMA as "the administration off a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering"[1].

SECTION 1: WHAT IS THE PHYSICIAN'S HEALER ROLE?

Opinion E-5.7 from the AMA Code states that "physician assisted suicide is fundamentally incompatible with the physician's healer role"[1]. However, the Code does not provide further explanation about how exactly PAS is incompatible with the healer role. Nor does the Code explain why it is concerned with the physician's role as healer rather than, say, the physician's role as curer. Lastly, the Code does not provide a definition of the physician's healer role or a characterization of what the healer role encompasses. The ambiguity found in Opinion E-5.7 leads to multiple interpretations behind PAD prohibition's reasoning. Determining PAD's compatibility with the physician's role as healer requires clearly defining that role.

A common understanding in the literature is that physicians have two essentials yet different roles: curing and healing[26-29]. Curing is straightforward and is the role that modern medicine tends to focus on[26,30]. However, there is little consensus about the healing role, which is less commonly discussed[31-35]. In this section, I will discuss the curing-healing dichotomy, as explicated by Cassell (1976) and Hutchinson et. al (2009). I will also briefly, discuss other conceptualizations and interpretations of the healing role found in the literature (Appendix I).

Eric Cassell contemplates the curing-healing dichotomy and concludes that most of the time the curing role shadows [eclipses] the healer role [26]. Moreover, the curing role is widely acknowledged [and desired][26]. Therefore, it is easier to associate the curing role with physicians; especially when the healing role lacks a straightforward definition[26]. For Cassell, curing means eradicating clinical symptoms (i.e. lowering fever), eliminating the source of infection (i.e. killing bacteria) and restoring functionality (i.e. enabling patient to breath better); in other words, curing is engaging with the disease[26]. However, beyond the disease there is illness, which

Table 1: Key Difference Between Curing and Healing based on Hutchinson et. al7

	Curing	Healing
Action	Eradicate disease or correct problem	Leads to a greater sense of integrity and wholeness
Goal	Survival (Avoid change)	Acceptance of change
Carried out by	Healthcare practitioner	Patient
Power Dynamic	Physician has more power	Patient has more power
Requires	Scientific knowledge, evidence-based practice	Gifts and characteristics as a person (both physician and patient)

involves the patient's fear, dependency, acceptance and understanding of the change their body endures[26]. For Cassell, these dimensions are outside the curing goals and purpose, and are the domain of healing, which encompasses the person enduring the disease[26].

Hutchinson et. al similarly describes the curing-healing dichotomy (see Table 1). For Hutchinson and colleagues, the curing role focuses on the correction of the problem (eradicate the disease) and the patient's survival without aiming for any physiological/mental change; the process is mainly led by the healthcare practitioner[27]. Meanwhile, the healing process aims to lead to a greater sense of integrity and wholeness, along with acceptance of change[27]. Unlike the curing role, the healing-role is dependent on the patient while the caregiver serves as a facilitator [27,36]. Beyond Cassell's and Hutchinson's understandings of the healing and curing roles, there are other definitions found in the literature[e] that have a similar take on the curing-healing

[e] In the face of poor search results regarding the definition of healer/healing/heal associated to the medical profession, the Hutchinson et. al article served as the beacon for literature research. I used Scopus and reviewed the 26 articles that cited the Hutchinson et. al's article. I repeated the same process with Google Scholar and reviewed the 54 articles that cited my designated beacon article. Afterward I reviewed the 101 articles that were related to the beacon article. The articles that contained relevant information, served as the new beacons. They were scanned in Scopus and Google Scholar for the other articles that cited them but not the related articles features. The process was repeated until reaching saturation. When adding the times cited per Scopus and Google Scholar 4,087 articles were reviewed (including repetitions). Eighty were chosen for an in-depth review for the thesis. Fifty-five articles were used, eight are still under review and 17 were not compatible with the discussion. From the 55 articles 28 articles

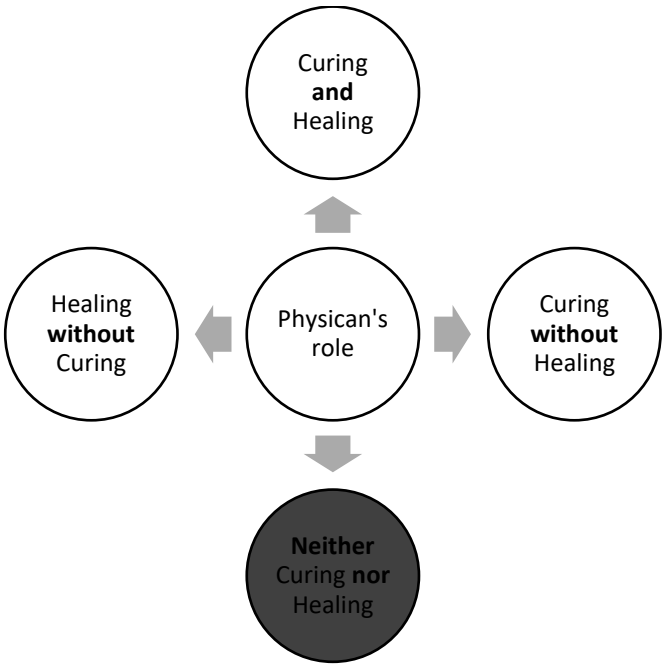
dichotomy. Overall, curing was perceived as the appropriate application of knowledge and techniques, embedded in the biomedical sciences, eradication of disease, objectiveness, focused on treatment [28,29,34,35,37,38] (Appendix I). Healing, on the other hand, was described as supportive, necessary for integrity and wholeness, involving a sense of understanding and acceptance, holistic, multidimensional, dependent of the individual; and a process independent of disease status, impairment status or death outcome [29-34,37-54] (Appendix I).

Nonetheless, there are other definitions in the literature that are unrelated to the Cassell and Hutchinson et. al conceptualization. At least two definitions involve healing as a mysterious phenomenon: either regarded as mystical power or associated with priests and magicians [28,55]. Contradiction was also observed. For some, healing existed if and only if both patient and caregiver acknowledge the process, whereas, another article claimed that healing can occur regardless of acknowledgment[30,44]. In some work healing and curing were used interchangeably. For example, healing was understood as "the repair of flesh" under a biomedical perspective; or considered as an intervention by "correcting pathological changes in the body, rather than enhancing wellbeing" [32,43]. Lastly, one definition did not distinguish healing from curing by stating that "healing meant being cured when possible, reduce suffering when cure was not possible […]"[56].

According to definitions found in the literature, a complete physiological and/or psychological recovery (a return to normal/basal function) should be expected during the curing

served as a recompilation of the healing definition; for those article that also had a curing definition it was added (Appendix I).

Figure 1: The four possibilities of physician's role. White circles are presumed to be easily accepted, whereas the shaded circle could be contested.



phase but not be expected during the healing phase. The healing role, instead, focuses on the acceptance of change, integrity and wholeness. Although healing and curing could occur simultaneously, each role can be applied independently.

Following the healing and curing dichotomy, physicians could engage in four combinations of healing and curing: curing without healing, healing without curing, curing and healing, and neither curing nor healing (Figure 1-Unshaded Circles). Curing without healing occurs when "the patient is not aware of being sick […] a good example is mild vitamin D deficiency" [28]. Not everyone desires nor needs healing all the time and most of the medical profession is focused on the disease-symptoms rather than the whole person [53,57] . The second scenario is healing without curing: when the goal is to reach "restoration of balance and the acceptance of status quo"[28], but there is no attempt to eradicate the disease or return to basal

level. The third scenario, curing and healing, would be the ideal; this is sometimees described as whole person medicine. Burn victims and rape victims in the acute stages are an example where curing and healing should be triggered simultaneously. Exclusively curing them would involve solely treating damaged tissues and complications (i.e. infections). However, adding the healer role would lead the encounter towards helping them adapt to change regarding their new physical, emotional and psychological states.

It is important to note that healing and curing are not always successful. For example, during the curing role, a physician may attempt a chemotherapy regimen with a patient who has cancer, and the patient may or may be not actively involved, working arm-to-arm with their physician. However, regardless of the effort from both parties, the therapy may not be successful. Similarly, a physician could engage in healing efforts, and yet not succeed in healing the patient. Like the curing role, the unsuccessful outcome does not necessarily mean a failure in the role performed. In other words, if chemotherapy did not succeed in curing a patient, it would be wrong to conclude that chemotherapy is incompatible with the physician's curing role.

SECTION 2: PAD IS SOMETIMES BUT NOT ALWAYS HEALING

The physician's curing role is to eradicate the disease and restore the patient to their basal state. PAD therefore is not curing. But could PAD ever be healing? Recall that healing, unlike curing, need not involve restoring physiological function or prolonging life, but rather is understood as involving acceptance of change and having/acquiring a sense of wholeness and integrity. Although it is counterintuitive to think that death can bring integrity and wholeness, this may be the truth for the terminally ill patient. For example, the case of Brittany Maynard, who was well-known in the last weeks of her life because of her advocacy for PAD, could be interpreted as successful healing.

Ms. Maynard was 29 years old when she was diagnosed with a glioblastoma in 2014[58]. The prognosis was poor, and doctors estimated six months of survival[59]. After months of research, she reached the conclusion that there was no life-saving treatment available, and that current recommendations (full brain radiation) would destroy the time she had left [59]. Mrs. Maynard also contemplated hospice and palliative care; however, she weighed the potential risk and benefits. Among the foreseeable harms she considered: "morphine-resistant pain, suffer personality changes, verbal, cognitive and motor loss; and due to her otherwise young and healthy body she would endure a longer time even though cancer would be eating her mind"[59]. Furthermore, she considered this process to be a "nightmare scenario for her family"[59]. She also made a bucket list which including celebrating her husband's birthday on late October and a trip to the Grand Canyon which she fulfilled; on November 1st she chose to pass away surrounded by her love ones at her home through PAD [58].

In the case of Brittany Maynard, she made arrangements to devote her remaining time to what she deemed important, and decided that palliative care was not compatible with her core values and her perception of her own life. Ms. Brittany Maynard wrote an opinion for CNN where she stated:

> *"I've had the medication for weeks. I am not suicidal. If I were, I would have consumed that medication long ago. I do not want to die. But I am dying. And I want to die on my own terms"*[59].

When reading her letter and hearing her videos, I could discern different aspects of healing that occurred for Ms. Maynard through the PAD process. She was a highly educated young women with a terminal disease, who after doing research along with her family, and weighing her own values, determined that PAD was right for her. Although not explicitly voiced, I believe that accomplishing her bucket list allowed her to keep and/or achieve her integrity and wholeness as a person. The closing of her letter suggest that PAD played an important role during her end of life, and that banning her from the opportunity could potentially tamper with her sense of integrity and wholeness through the dying process:

> *"When my suffering becomes too great, I can say to all those I love, "I love you; come be by my side, and come say goodbye as I pass into whatever's next." I will die upstairs in my bedroom with my husband, mother, stepfather and best friend by my side and pass peacefully. I can't imagine trying to rob anyone else of that choice"*[59].

Thus, Ms. Maynard's case seems to be an example of healing PAD.

Regardless of cases like Brittany Maynard's, the reality is that PAD is not always healing. End of life circumstances and personal responses are different for each individual [26]. The dying process is not always one of preserving wholeness and integrity: this may not be

consistent with patients' cultural perceptions of death, or with patients' struggle for control during the dying process. In such circumstances, the PAD process is not an instance of healing. Consider the following hypothetical example.

Ms. Rivera is a 30-year-old woman with end stage cancer. She is currently in pain and bedbound; hooked up to different machines; soon to be intubated in the near future. Ms. Rivera had constantly expressed that she would rather die in the comfort of her home with her loved one, bypassing this terrible scenario. She did not have a bucket list nor any special plan with the remaining days of her life. However she voiced the following: "I just want to be at home with all my family, I want to have time to say goodbye…I don't want to end alone, hooked up to machines, surrounded by strangers, for me that is sad and awful". A few days pass, Ms. Rivera's health condition continues to deteriorate. The healthcare team feels uncomfortable in providing CPR, since it is their belief that it will cause more harm than benefit to Ms. Rivera. The hospital's ethics committee is called, and it is determined that the team is not obligated to provide resuscitation in the face of medical futility. A few days later Ms. Rivera passes away in the hospital setting, alone...

In this case Ms. Rivera expressed her desire for PAD without explicit expressing thoughts that suggest PAD will preserve her "wholeness and integrity". Unlike Ms. Maynard's case, it is less clear with Ms. Rivera whether she would had achieved wholeness or integrity. Nonetheless, Ms. Rivera did have ideas about how she wanted to die. It is very clear that Ms. Rivera wanted to diminish her suffering by being in a familiar setting (her home), surrounded by loved ones. In a sense, PAD for Ms. Rivera would be a form of damage control that mitigates the emotional suffering associated with dying .

To give another example, Erwin Cherinsky tell his experience when his father was dying of terminal lung cancer at the hospital:

> "Fourteen years ago, in the spring of 1993, my father was dying of terminal lung cancer. Near the end of his life, he was in the hospital, far too weak to get out of bed or even to shave. Except when sedated, he was fully conscious and completely rational. He completely understood that he was in the last days of his life and that he would never get out of that hospital bed. I stood next to him as he asked a doctor to administer drugs to end his life. He cogently explained to the doctor that either he was awake and in great pain or he was drugged into unconsciousness. He told the doctor that it was his time to go and there was no point in prolonging his life a few more days. No one in my family objected to his choice. The doctor brusquely said, "I can't do that," and quickly changed the subject. My father, though, was persistent and again asked the doctor to give him enough morphine to stop his breathing and end his suffering."[60]

In comparison with the previous cases, this case tends to lean more toward suffering control rather than achieving wholeness and integrity. At this point of the disease, it is less likely that healing could be achieved, even if the patient is kept alive. Recall that the healing phase is characterized by the patient's acceptance of change and achieving a state of integrity and wholeness, which are determined by the patient's core value and perception of the dying process. The following paragraph describes the final days of Mr. Chemerinsky's father:

> "He was awake for increasingly short intervals and while awake he complained of great pain. The tumor had blocked circulation to his arm and it was grotesquely swollen. He did not see any point in having an amputation since he was about to die. He told the doctor that at that stage it did not matter to him whether he died of gangrene from the death of tissue in his arm or from the lung cancer"[60].

Unlike Ms. Maynard's case, PAD in this case would be more like non-healing PAD than healing PAD. But was denying non-healing PAD a good alternative? Did it help to promote healing? Did it help the patient acquire greater integrity and wholeness? It would seem not. Then what is the benefit of withholding non-healing PAD in these cases? In fact, forcing the patient to remain

alive during his final days placed him at risk of losing his wholeness and integrity by enduring the deteriorating conditions of the disease, which the patient would rather not endure.

> "My father died four days after making that request. I will never understand what interest the State of Indiana, where he was in the hospital, had in keeping him alive for those few additional days. But a person like my father, who desperately wanted to end his suffering, was left with no alternatives. Thankfully, he only lingered for a few days after his request; but there are many terminally ill patients who suffer for months because of the lack of a right to death with dignity[60]".

Unlike the case of Ms. Maynard, these two last scenarios are most likely examples of non-healing PAD – a PAD that does not achieve or preserve integrity and wholeness, but just limits suffering and returns some control to the individual during the dying process. Returning to AMA position, the question now is: is non-healing PAD fundamentally incompatible with the physician's healer role? The next section considers this question.

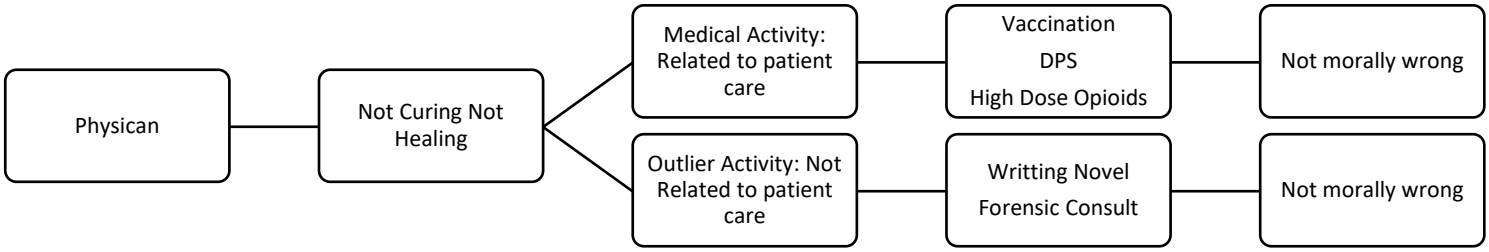
SECTION 3: IS ENGAGING IN NON-HEALING PAD COMPATIBLE WITH THE PHYSICIAN'S ROLE AS HEALER?

The AMA Code of Ethics claims that PAD is fundamentally incompatible with the physician's role as healer. But in what way is it incompatible? Is PAD incompatible because most of the time PAD does not heal? Is it incompatible because it does not allow the patient to undergo a further healing process? Or something else? Steven Luper addressed this unclarity of Opinion E-5.7 in his 2016 paper "The AMA on Euthanasia and Assisted Suicide" [61]. In this sections I will introduce, expand and discuss Luper's reasons and objections behind the AMA PAD prohibition.

Luper offers three interpretations for the AMA's claim that PAD is incompatible with the physician's healer role, and rebuts each one of them (Appendix II). Luper's first interpretation is that "Physicians ought not to supplement their role as healers" [61]. He responds that physicians engaging in activities beyond healing is not morally wrong, and provides the following examples where medical expertise is used outside the context of healing: entertainment (i.e. writing novels), fighting crime (i.e. forensic consult) or enhancing people's appearance (i.e. elective cosmetic surgery[61]. Even though I agree with Luper's objection, it does not address activities that occur within the medical context during patient care. Activities such as writing novels or serving as a forensic consult are actions that are out of the context of patient care[f]. A closer analogy to PAD is activities that physicians engage in *as part of patient care* that do not include curing nor healing. For example, preventive measures (i.e. vaccines) are not targeted to cure nor heal, yet they are accepted component of patient care. Interventions that solely relieve

[f] Plastic surgery could be debated as a treatment to oneself inconformity or as fueling societal pressures into an individual, however, such discussion is not the purpose of this article.

Figure 2: Not curing not healing map flow. Outlier Activities are based in Luper's article.



suffering are another example. Deep palliative sedation (DPS), which is the "intentional induction of loss of consciousness for the purpose of symptom relief [62]; and similarly, high dose opioids for pain at the end of life; is neither curing, nor is it healing. Following the plausible reason, even high dosage opioids could be seen as interfering with healing, because they blunt the patient's awareness, not allowing them to participate in the acquisition of wholeness, integrity and acceptance of change at the end of life. Yet, these non-healing, non-curing actions are not deemed incompatible with the physician's role as a healer; or else both would have been prohibited by the AMA code. Figure 2 expand medical activities related to patient care that are not considered immoral yet are not considered curing nor healing contrasted with Luper's example.

The second interpretation suggested by Luper is it is objectionable for physicians to use their medical expertise in any way that interferes with their healer role[61]. During the discussion Luper argues that "people would come to distrust physicians if physician assisted suicide becomes part of medical practice" and due to that "people will make less use of [physician] expertise"[61g].

[g] Luper's objection involves a series of reasons: "A more plausible charge is that physicians ought not to use their medical expertise in any way that precludes healing. This would be grounds for them not to help patients die,

Luper responds that PAD will not interfere with the physician healer role if and only if it is implemented correctly, hence avoiding patient distrust even if PAD becomes part of medical practice[61]. In other words, physician trust depends on the appropriateness of the medical intervention and its implementation. For example, if correctly applied, amputation is a potential life-saving procedure. However, if a physician performs an amputation, and the patient later knows that he was a potential candidate for a limb salvage procedure, he will distrust the physician. Even if they ended up choosing amputation over the limb-salvage procedure, the physician wrongly imposed his medical expertise and set of values on the patient. Yet this risk of distrust is not enough reason to forbid amputation from the medical profession.

Another example would be if a patient, who would appreciate being more lucid to share time with their loved one at the expense of enduring more suffering, will not trust the physician if the physician keeps increasing pain medication. The same occurs during the curing role, a blood transfusion may cure a patient, but if the patient has a firm religious belief against blood transfusion, and yet his physician proceeds, this will cause distrust. The same can be applied to healing and non-healing PAD. If a patient could potentially benefit from PAD, however, just like the amputation example, the patient does not find the intervention compatible and/or in accordance with their value; and their physician still prescribe them the pills; this will surely cause distress and distrust. In other words, PAD is susceptible (just like any other medical

assuming that they cannot provide such help if they are healers. (According to Boudreau and Somerville [2013], helping patients die and healing them are "simply not miscible" [62].) However, it is clearly hyperbole to say that physicians cannot do both. It is true that physicians cannot prolong a particular person's life and assist in the death of that very person at the same time, but they can help prolong the lives of people who seek that kind of attention and help other people who wish to die, just as veterinarians can meet the needs of people who want their animals healed even while accommodating those who want their suffering pets euthanized. Obviously, physicians can do both, but perhaps a weaker charge is intended, namely that it is objectionable for physicians to use their medical expertise in any way that interferes with their role as healers. Here the worry might be that people would come to distrust physicians and to make less use of their expertise if PAS or PE becomes part of their practice (Boudreau and Somerville 2013; Steinhauser et al. 2000)[61]".

intervention) to the physician's communication and clinical skills. Regardless of the physician's good intentions, if the physician forces their medical expertise and impose their own values, there is a high probability that the physician will undermine patient trust.

Luper's third interpretation of the claim is that physicians should not engage in activities that preclude healing[61]. Luper responds that physicians can engage in PAD with some patients and heal other patients, similar to veterinarian practice[61]. In other words, physician can wear different hats, engaging in PAD with some patients without precluding the healing of other patients. A more straightforward example of Luper's objection is when a physician can accommodate a radical mastectomy for patient and lumpectomy combined with radiation in another that prefers the second technique, without either curing method precluding the other. Similarly, at the end of life, physicians could accommodate patients that want to pursue PAD, as well as those that want to pursue life prolongation. Shibata offers the following conclusion that resonates with Luper's objection "where PAS [PAD] fails, palliative care can succeed and vice versa"[7].

However, it might be that Luper isn't getting at what worries the AMA. Possibly the AMA is not only worried about the use of PAD in patients who desire such intervention precluding not using PAD in other patients. Perhaps rather, the AMA is concerned that PAD precludes healing in the patients who opt for it. Therefore, if a physician engages in PAD with a patient, then it will preclude the chance of healing that patient; and precluding healing is unacceptable. There's a problem with this view. If healing involves a transformative process of accepting change, and reaching a state of wholeness and integrity, then anything that precludes this process is incompatible with the physician's role as healer. If this is true, then the curing role (which attempts to restore the patient to their previous state without undergoing a transformative

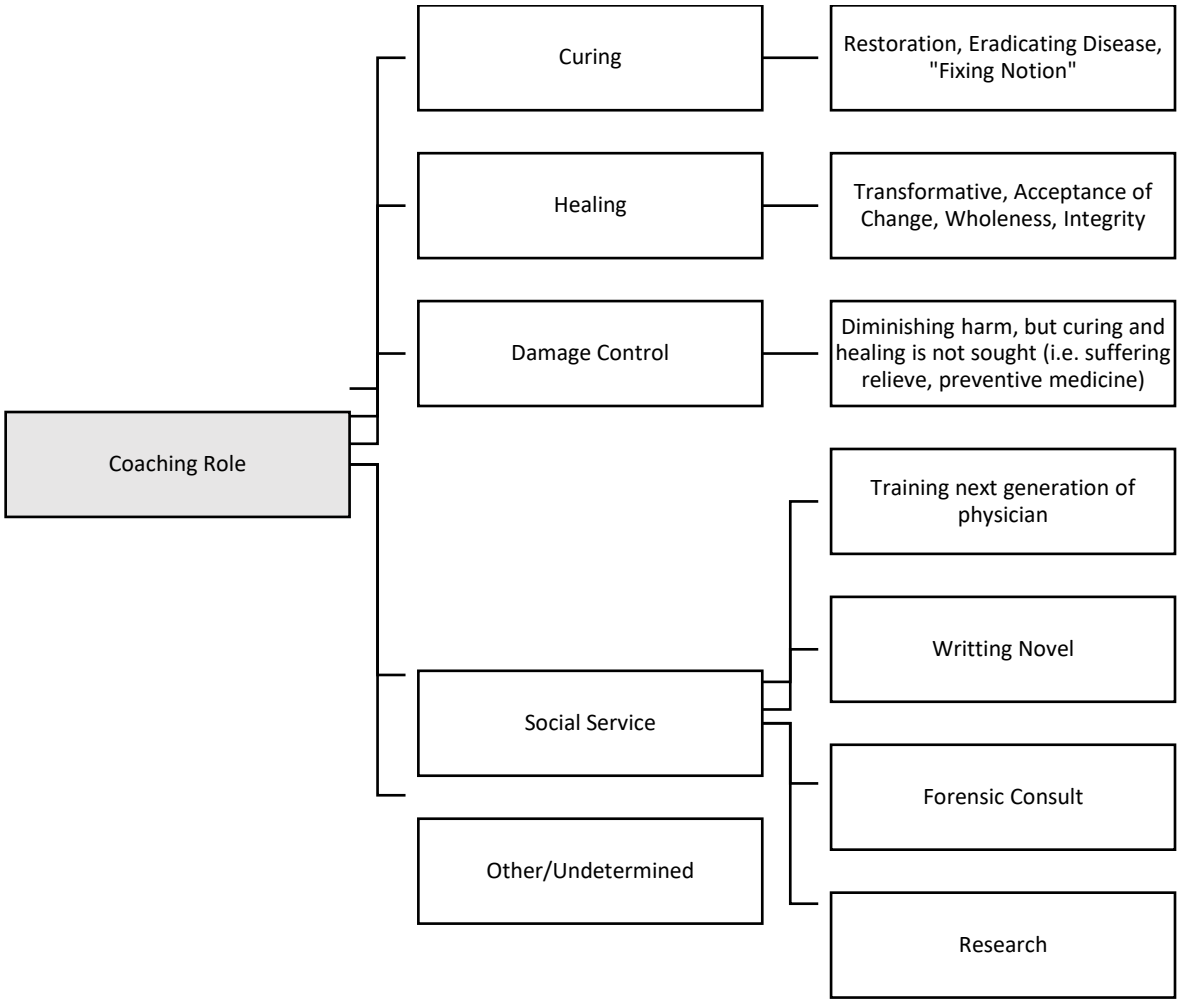
process) would be prohibited. The same would be concluded with high-dose pain medication at the end of life, which interferes with a patient's consciousness and awareness – an example of an intervention that arguably could preclude healing yet is acceptable in the medical profession. It is absurd to suggest that offering pain medication at the end of life is inappropriate because patients need to be kept awake and aware to avoid precluding a chance at healing (recall Mr. Chemerinsky's father's case).

Clearly this shows that the medical profession is more than just healing and curing, since both are not always possible. If so, then there must be other roles beyond curing and healing that are compatible with the medical profession. In the next section I offer the Coaching Role concept as an umbrella role for the roles in the medical profession. I argue that non-healing PAD can be compatible with the physician's coaching role and thus is not incompatible with the physician's role overall.

SECTION 4: THE COACHING ROLE: AN UMBRELLA FOR HEALING, CURING, AND BEYOND

In this section, I will introduce the Coaching Role as a possible interpretation of the physician's role. Coaching involves teaching, instructing, training and prompting someone[63]. Limiting medical activities to the healing-curing dichotomy does not encompass all the activities where medical expertise is involved (Figure 3). Throughout all the human stages of life, the medical profession is tasked with coaching different events such as aiding in birth processes (obstetrics, artificial fertilization), preserving health by either avoiding diseases (preventive medicine) or addressing them (primary and specialties), improving life quality (through the healing role), among others. It should not be surprising that during the dying process, coaching is engaged. Cassell states that physicians can and should teach patients how to die and make the patient's final process a meaningful and positive one[26]. In other words, this involves lending medical knowledge to patients in order to navigate their last stage, but not necessarily with the goals of healing in mind.

Figure 3: The Coaching Role as an umbrella term that encompasses all the medical activities done in the physician role.



My conception of the Coaching Role was inspired by Cassell's representation of the physician-death relationship using the Nordic myth *The Tale of Utgard Loki*[h]. In the comparison, the physician is Thor, who loses a wrestling match against Elli (old age); depicting the constant struggle that physician [and everyone else] encounters with their mortal status[26]. Below is the passage from Cassell's book *The Healer's Art*, the words in bold shows what I deem important in the discussion of the coaching role:

> "***Angered by his failure**, Thor called on the King to have someone wrestle with him." The King said, "You will wrestle with that old crone, my nurse Elli. She has wrestled many no less strong than you." […] The more Thor leaned into his grip, the firmer she stood. **The struggle was violent, but slowly Thor gave ground, and finally, his foot slipping, he was brought down on one knee**. The King ordered them to stop […] "Now I must tell you the truth…wrestling Elli was the most astonishing feat, **for she is Old Age- and there is no man, now or ever, that death will not sooner or later lay low**"*[26].

On this depiction, the physician (Thor) is the protagonist, the disease (Elli) is the mortal nemesis, and the patient is the battlefield upon which the physician fights (the physician either "won" against the disease or the patient "lost the battle" against the disease)[52,64,65]. The coaching role aims to return the spotlight to the patient, and to frame the patient as the protagonist fighting against mortality, and to highlight the importance of physician as supporters – or coaches - against the fight with mortality.

What better coach than someone who trained for at least 7-9 years[i] and then dedicated their professional life to provide advice, support and intervention at these types of matches? Just

[h] The chapter's title is *The Healer's Battle*

[i] Four year of United States Medical School and 3-5 years depending on the Residency Program. If Fellowship is pursued more years of training are added.

like a coach helps a player throughout a game by shouting instruction, formulating strategies and bringing beverages during a game, a physician-coach can help the patient throughout their lives, including at the end of life. Another compelling coaching example is seen in Pediatrics. A pediatrician coaches parents in developing the right strategy with their child. An insightful coach, who has witnessed many games before, shouts suggestions to the new parents through the brutal first few innings with their little one. The Coaching Role offers a broader view of the physician's role, rather than just curing-healing roles, and is consistent with the physician choosing from an array of interventions at the end of life that are consistent with the patient's values (Figure 3).

Returning to Cassell's analogy if we see the patient (instead of the physician) as Thor, and see the physician as Eir (the Nordic goddess associated with the healing arts), standing quietly behind Thor, we can see how the coaching role might play out. If during the arm-wrestling match, Elli twists her hand and makes Thor succumb to sick sinus syndrome, Eir can recommend a pacemaker; extending the match's duration. If Elli tampered with Thor's mental health and he would like to throw in the towel, Eir will firmly place her hand on Thor's neck and even directly guide his hand through the match (i.e. involuntary hospitalization). In both previous cases, the physician (the coach) decided to engage in curing. The physician (as coach) might also, sometimes, cease curing and engage in healing.

But what should physicians do when everyone knows the match is definitely coming to an end, because the patient is terminally ill, and the patient turns their head toward their coach and asks, "help me to end the match"? Those who've wrestled with someone much stronger than themselves know there is a moment where your biceps hurt too much. There is a point of no return where everyone knows that the match is lost, but the winning party is taking its own time,

or the losing party is been encouraged to keep struggling. This last lag of the match turns into a vice and cruel grip. As a good coach, Eir will offer all available alternative (DPS, pain management, DNR/DNI) and will try to engage in healing techniques that may help preserve the patient's integrity and wholeness. But if the patient shakes their head and asks once again to teach and guide them on how to end the match, is this not an acceptable way for the physician to coach the patient? Why, then, would PAD be deemed incompatible with the medical profession?

Under this situation, would it be enough if Eir just patted Thor's shoulder sympathetically and kept quiet in a situation of extended suffering, allowing Elli to take her time? Should Eir clear her throat and repeat, once again, the other options? I believe that under these strict conditions, physicians should be allowed to coach patients in how to end the match sooner. Recall the case of Ms. Brittany Maynard and Chemerinsky's father. There is a difference between wanting to die versus wanting to control the dying process when you are already dying. Patients are asking to be taught how to die and how to have control over their dying process[26].

How would coaching looks like in these two similar yet very different situations? Continuing with the analogy, during non-healing PAD, Thor looks to Eir and worries that giving up the match will lead Elli to violently break his arm, causing too much to pain to endure. Eir shows Thor how to position his body so that ending the match is painless. Eir coaches Thor in controlling his dying process. In healing PAD, in contrast, Thor is not afraid of pain, but of becoming a different person during the dying process. His main goal is not to avoid pain, but to know how to end the match on his own terms, in a dignified way that does not injury his integrity and wholeness; a way that make sense of the entire match to that point. Eir can also show Thor how to position his body so that ending the match still preserves Thor's wholeness and integrity.

Both are example of reasonable jobs for a coach. Healing and Non-healing PAD are justifiable reasons for wanting and needing a coach.

Lastly, death is an irreversible harm, and therefore there is an instinct to avoid it. Both healing and non-healing PAD leads towards death. However, we must acknowledge that death is the expected and unequivocal outcome during the dying process of the terminally ill patients. If medicine is tasked to guard different human stages (before, during and after life) and the physicians are the keepers of these stages[26], then-in some cases, "hastening [the patient's] death should be viewed as part of a continuum of medical care"[66].

SECTION 5: BOUNDARIES AND LIMITATIONS OF THE COACHING ROLE

Are there limits to the Coaching Role? Absolutely, just like any other role in the medical profession, the coaching role has limitations. In a professional perspective, the Coaching Role is limited to patient care or any interaction related to medical care and well-being tightly linked to health, life and death. In other words, coaching a parent how to drive a car is outside the scope of the physician's coaching role, but coaching them in choosing the correct car seat for their child falls within the profession's responsibility. This is an example were the physician is not engaging in the two traditional roles of curing or healing, but nonetheless is engaged in the overall care of the pediatric patient.

Does the Coaching Role encompass ***any*** way that the physician could provide benefit to patients within medical contexts? If Coaching is not limited to curing and healing in medical context, where are its boundaries? For example, imagine a physician participating in torture. Suppose that the physician is leading the torture session, lending their knowledge ("coaching") on how to effectively maximize pain and suffering without jeopardizing the victim's life. This would be a form of coaching, but a morally wrong form of coaching, because the physician is inflicting harm. But what if, instead, the physician is providing healthcare to the victim, knowing that the purpose is to keep the victim alive for further information extraction, therefore perpetuating the harm of the torture? Undeniably torture is an opportunity to engage in the Coaching Role, but it is not an ethical one.

Another plausible concern is whether the Coaching Role includes the mitigation of any and all types of human suffering. The medical profession should not be responsible for mitigating all human suffering[67]. For example, diminishing world hunger is not a moral

obligation of the medical profession, because world hunger is not an expected task within the physician's role. However, the suffering endured by terminally ill patients falls within the boundary of the healthcare professionals' responsibilities because it is the product of the underlying diseases and treatment. For example, mitigating suffering with non-healing PAD is an intervention that falls within the proper scope of the medical profession.

Does this mean that since the dying process belongs to the medical profession, PAD should be offered to every patient that asks for PAD? Of course not. Should a physician give antibiotics for a viral disease just because the patient asked for it? No. The same is true with PAD, and in fact with any other medical intervention. A physician facilitating death due to the pain cause by an ingrown nail is not the same when the physician facilitates the death of a terminally ill, in other words, already dying patient. The permissibility of an action depends on the specifics of the case and the balancing of ethical principles of that case.

CONCLUSION

This paper has argued against the claim, found in the AMA Code of Ethics, that physician assisted suicide is "fundamentally incompatible with the physician's healer role"[1]. I've argued that physician assisted death may be a form of healing for patients, in certain selected cases. Even when PAD is not a form of healing for the patient, it may be compatible with the physician's healer role when correctly performed. As shown by Luper in 2016 and this article, there are actions performed by physicians that go beyond the curing or healing roles yet they are necessary and appropriate. I've suggested that we conceive the physician role more broadly, as a coaching role that includes curing, healing, and actions beyond both curing and healing. The Coaching Role places the patient into the protagonist role and the physician as a more supportive role governed by the biomedical principles. At the end of life, like any stage during the lifespan, the physician advises the patient in their personal match against their mortality. Physician assisted death could be considered an acceptable method of coaching, even when it is not healing, if it corresponds with the patient's values and goals during their dying process and conforms with other ethical requirements. Therefore, PAD is consistent with the physician's role.

Physicians develop a patient-physician relationship with patients, which serves as a safety net, allowing the physician to screen for the patient's value, capacity status, and health status, as well as providing alternatives to patients that align with their own values. Moreover, this would be an opportunity for the medical field to have an input in the guidelines and framework of PAD. Although the AMA Code of Ethics is not legally binding, it influences the behavior of the medical professional. Therefore, it is important that the Code of Ethics has a nuanced understanding of PAD and one that provides guidance for physicians participating in PAD.

REFERENCES

1. American Medical Association. *Code of medical ethics.* Newburyport: American Medical Association; 2016. http://ebookcentral.proquest.com/lib/jhu/detail.action?docID=5567901.

2. Death with Dignity. For healthcare providers https://www.deathwithdignity.org/learn/healthcare-providers/. Updated n.d. Accessed 11/29/, 2019.

3. CNN Library. Physician-assisted suicide fast facts. . Updated 2019. Accessed Nov 29, 2019.

4. Jonsen AR, Siegler M, Winslade WJ. *Clinical ethics : A practical approach to ethical decisions in clinical medicine.* Eighth ed. New York: McGraw-Hill; 2015. http://accessmedicine.mhmedical.com/book.aspx?bookid=1521.

5. Barutta J, Vollmann J. Physician-assisted death with limited access to palliative care. *J Med Ethics*. 2015;41(8):652-654. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84938555414&doi=10.1136%2fmedethics-2013-101953&partnerID=40&md5=69de3c638e7b59447fa7508ba6f80482. Accessed 29 August 2019. doi: 10.1136/medethics-2013-101953.

6. Donald Boudreau J, Somerville MA. Euthanasia is not medical treatment. *Br Med Bull*. 2013;106(1):45-66. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84878853730&doi=10.1093%2fbmb%2fldt010&partnerID=40&md5=32db33c23d328dcdd926cd599c6e9d85. Accessed 30 August 2019. doi: 10.1093/bmb/ldt010.

7. Shibata B. An ethical analysis of euthanasia and physician-assisted suicide: Rejecting euthanasia and accepting physician assisted suicide with palliative care. *J Leg Med*. 2017;37(1-2):155-166. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85029584938&doi=10.1080%2f01947648.2017.1303354&partnerID=40&md5=e294563b530d33acad852da4b181ae79. Accessed 31 August 2019. doi: 10.1080/01947648.2017.1303354.

8. Hooke AE. An ethics of accompanying the dying: Reflections on the work of alphonso lingis. *Philosophy Today*. 1997;41(Supplement):153-160.

9. Death with Dignity. Impact of death with dignity https://www.deathwithdignity.org/faqs/. Updated n.d. Accessed December 5, 2018.

10. Fifield K. American medical association votes on doctor-assisted suicide. https://www.aarp.org/health/conditions-treatments/info-2018/physician-assisted-suicide-terminally-ill.html. Updated 2018. Accessed Dec 6, 2018.

11. Pies RW. Will the AMA heed its own ethics council regarding assisted suicide? https://www.psychiatrictimes.com/couch-crisis/will-ama-heed-its-own-ethics-council-regarding-assisted-suicide. Updated 2018. Accessed January 11, 2019.

12. Miles SH. *The hippocratic oath and the ethics of medicine.* Oxford University Press; 2005.

13. Vacco v. quill. . 1997;521:793.

14. Washington v. glucksberg. . 1997;521:702.

15. Quill TE, Sussman B. Physician-assisted death. https://www.thehastingscenter.org/briefingbook/physician-assisted-death/. Updated n.d. Accessed Aug 31, 2019.

16. Washington State Legislature. Chapter 70.245 RCW the washington death with dignity act. https://app.leg.wa.gov/RCW/default.aspx?cite=70.245. Updated n.d. Accessed Nov 29, 2019.

17. Denys D. Is euthanasia psychiatric treatment? the struggle with death on request in the netherlands. *Am J Psychiatry*. 2018;175(9):822-823.

18. Dresser R. On legalizing physician-assisted death for dementia. *Hastings Cent Rep*. 2017;47(4):5-6.

19. Chhikara N. Extending the practice of physician-assisted suicide to competent minors. *Family Court Review*. 2017;55(3):430-443.

20. Beckwith J. A cry for help: Preventing passive euthanasia decision-making for neonates with non-fatal congenital defects. *J LEGAL MED*. 2013;34(3):273-294.

21. Rurup ML, Onwuteaka-Philipsen BD, van der Wal G, van der Maas, P. J. A 'suicide pill' for older people: Attitudes of physicians, the general population, and relatives of patients who died after euthanasia or physician-assisted suicide in the netherlands. *Death Stud*. 2005;29(6):519-534.

22. Florijn BW. Extending'euthanasia to those 'tired of living'in the netherlands could jeopardize a well-functioning practice of physicians' assessment of a patient's request for death. *Health Policy*. 2018;122(3):315-319.

23. Hedberg K, New C. Oregon's death with dignity act: 20 years of experience to inform the debate. *Ann Intern Med*. 2017;167(8):579-583.

24. Meier DE, Emmons C, Litke A, Wallenstein S, Morrison RS. Characteristics of patients requesting and receiving physician-assisted death. *Arch Intern Med*. 2003;163(13):1537-1542.

25. Smith KA, Harvath TA, Goy ER, Ganzini L. Predictors of pursuit of physician-assisted death. *Journal of Pain and Symptom Management*. 2015;49(3):555-561. http://www.sciencedirect.com.proxy1.library.jhu.edu/science/article/pii/S0885392414003984. doi: //doi-org.proxy1.library.jhu.edu/10.1016/j.jpainsymman.2014.06.010.

26. Cassel EJ. The healer's art: A new approach to the doctor-patient relationship. . 1976.

27. Hutchinson TA, Hutchinson N, Arnaert A. Whole person care: Encompassing the two faces of medicine. *CMAJ*. 2009;180(8):845-846.

28. Szawarska D. Curing and healing: Two goals of medicine. In: *Handbook of the philosophy of medicine.* ; 2017:83-92. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85042820924&doi=10.1007%2f978-94-017-8688-1_59&partnerID=40&md5=1be59979e039abfa7d7b36e25aaa69e4. Accessed 29 August 2019. 10.1007/978-94-017-8688-1_59.

29. Krajnik M. Whole person care: A hope for modern medicine? *Poli Arch of Inter Medi*. 2017;127(10):712-714. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85034079036&doi=10.20452%2fpamw.4100&partnerID=40&md5=86e76326953feec75df3e0b9ec9aefbf. Accessed 30 August 2019. doi: 10.20452/pamw.4100.

30. Meza JP, Fahoome GF. The development of an instrument for measuring healing. *Ann Fam Med*. 2008;6(4):355-360. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-48249099313&doi=10.1370%2fafm.869&partnerID=40&md5=9fc570f36565b51379167c7fc6764a19. Accessed 30 August 2019. doi: 10.1370/afm.869.

31. Egnew TR. Meaning, medicine, and healing. In: Russo-Netzer P, Schulenberg SE, Batthyany A, eds. *Clinical perspectives on meaning: Positive and existential psychotherapy.* Cham: Springer International Publishing; 2016:299-321. https://doi.org/10.1007/978-3-319-41397-6_15. 10.1007/978-3-319-41397-6_15.

32. Levin J. What is "Healing"?: Reflections on diagnostic criteria, nosology, and etiology. *Explor*. 2017;13(4):244-256. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85020163086&doi=10.1016%2fj.explore.2017.04.005&partnerID=40&md5=150db5d4a55e18e0a39aee1af190f573. Accessed 31 August 2019. doi: 10.1016/j.explore.2017.04.005.

33. Rahtz E, Warber SL, Dieppe P. Understanding public perceptions of healing: An arts-based qualitative study. *Complement Ther Med*. 2019;45:25-32. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85065892745&doi=10.1016%2fj.ctim.2019.05.013&partnerID=40&md5=4ae06e0cf461cb73d8505bfe282501b0. Accessed 31 August 2019. doi: 10.1016/j.ctim.2019.05.013.

34. Sajja A, Puchalski C. Healing in modern medicine. *Ann Palliat Med*. 2017;6(3):206-210. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85025070044&doi=10.21037%2fapm.2017.06.18&partnerID=40&md5=52fc877e8f16bfd4411bef2ca558930a. Accessed 30 August 2019. doi: 10.21037/apm.2017.06.18.

35. Sternszus R, Regehr G. When I say … healing. *Med Educ*. 2018;52(2):148-149. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85028938748&doi=10.1111%2fmedu.13413&partnerID=40&md5=dcb0e97d80b54bf7178deabd8fdb776f. Accessed 30 August 2019. doi: 10.1111/medu.13413.

36. Mount B. Healing, quality of life, and the need for a paradigm shift in health care. *J Palliative Care*. 2013;29(1):45-48. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84875850717&partnerID=40&md5=a4544f857130e17085e02e49c5741429. Accessed 31 August 2019.

37. Hutchinson TA. Whole person care. In: *Whole person care.* Springer; 2011:1-8.

38. Firth K, Smith K, Sakallaris BR, Bellanti DM, Crawford C, Avant KC. Healing, a concept analysis. *Global advances in health and medicine*. 2015;4(6):44-50.

39. Mount B, Kearney M. Healing and palliative care: Charting our way forward. *Palliat Med*. 2003;17(8):657. http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=14694915&site=ehost-live&scope=site.

40. Liggins J. Healing the heart of recovery. *Int J Soc Psychiatry*. 2018;64(7):660-667. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85053402231&doi=10.1177%2f0020764018796538&partnerID=40&md5=f1dffc901477f9b655c9f9839fef7ac6. Accessed 29 August 2019. doi: 10.1177/0020764018796538.

41. Anderson EW, Frazer MS, Schellinger SE. Combining best practices and patient, caregiver, and healthcare provider perspectives for late-life supportive care: LifeCourse. *J Nurs Adm*. 2017;47(11):551-557. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85032621647&doi=10.1097%2fNNA.0000000000000542&partnerID=40&md5=7447711ebccd081d8a50df5fcd5ca8d1. Accessed 29 August 2019. doi: 10.1097/NNA.0000000000000542.

42. Feudtner C. Hope and the prospects of healing at the end of life. *J Altern Complement Med*. 2005;11(SUPPL. 1):S-30. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-29344441041&partnerID=40&md5=e25c1d7e9ed1d5c15c1a5d3ff70f720a. Accessed 30 August 2019.

43. Dieppe P, Roe C, Warber SL. Caring and healing in health care: The evidence base. *Int J Nurs Stud*. 2015;52(10):1539-1541. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84933060364&doi=10.1016%2fj.ijnurstu.2015.05.015&partnerID=40&md5=7653a361efce9723716ed0b45092fc38. Accessed 30 August 2019. doi: 10.1016/j.ijnurstu.2015.05.015.

44. Marshall ES. Home as place for healing. *Adv Nurs Sci*. 2008;31(3):259-267. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-54549096821&doi=10.1097%2f01.ANS.0000334289.04225.68&partnerID=40&md5=a420bd865c379b8655d8fcc215d7872d. Accessed 30 August 2019. doi: 10.1097/01.ANS.0000334289.04225.68.

45. Hutchinson TA, Mount BM, Kearney M. The healing journey. In: Hutchinson TA, ed. *Whole person care: A new paradigm for the 21st century.* New York, NY: Springer New York; 2011:23-30. https://doi.org/10.1007/978-1-4419-9440-0_3. 10.1007/978-1-4419-9440-0_3.

46. Kenny G. The healers journey: A literature review. *Complement Ther Clin Pract*. 2012;18(1):31-36. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84455161056&doi=10.1016%2fj.ctcp.2011.08.002&partnerID=40&md5=836c239782ee20cfb8d5ffb8254bd1a3. Accessed 30 August 2019. doi: 10.1016/j.ctcp.2011.08.002.

47. Eustache C, Jibb E, Grossman M. Exploring hope and healing in patients living with advanced non-small cell lung cancer. *Oncol Nurs Forum*. 2014;41(5):497-508. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84908480212&doi=10.1188%2f14.ONF.497-508&partnerID=40&md5=5c87b3538e09557dff733585cd3cbd25. Accessed 31 August 2019. doi: 10.1188/14.ONF.497-508.

48. Glannon W. Transcendence and healing. *Med Humanit*. 2004;30(2):70-73. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-11144344975&doi=10.1136%2fjmh.2002.000145&partnerID=40&md5=3993f04be5a9c4729eb069575cceaf1c. Accessed 31 August 2019. doi: 10.1136/jmh.2002.000145.

49. Glaister JA. Healing: Analysis of the concept. *Int J Nurs Pract*. 2001;7(2):63-68. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-0035323261&doi=10.1046%2fj.1440-172X.2001.00255.x&partnerID=40&md5=31952795b56a164bfb350aa454c0d686. Accessed 2 September 2019. doi: 10.1046/j.1440-172X.2001.00255.x.

50. Gauthier DM. The meaning of healing near the end of life. *J Hospice Palliative Nurs*. 2002;4(4):220-227. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-33748493357&doi=10.1097%2f00129191-200210000-00018&partnerID=40&md5=82249811342f861a77bc40dd41bd93c7. Accessed 2 September 2019. doi: 10.1097/00129191-200210000-00018.

51. Dobkin PL. Fostering healing through mindfulness in the context of medical practice. *Current Oncology*. 2009;16(2):4.

52. Egnew TR. The meaning of healing: Transcending suffering. *Annals of Family Medicine*. 2005;3(3):255-262. http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=17364551&site=ehost-live&scope=site. doi: 10.1370/afm.313.

53. Egnew TR. Suffering, meaning, and healing: Challenges of contemporary medicine. *Ann Fam Med*. 2009;7(2):170-175. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-66249114649&doi=10.1370%2fafm.943&partnerID=40&md5=1d09fbd3358b61cba732d0f0f8dd538c. Accessed 30 August 2019. doi: 10.1370/afm.943.

54. Gopichandran V. Faith healing and faith in healing. *Indian J Med Ethics*. 2015;12(4):238-240. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-84983231299&partnerID=40&md5=79f6863d557e48b2df957701f18cc624. Accessed 31 August 2019.

55. Orfanos CE. From hippocrates to modern medicine. *Journal of the European Academy of Dermatology and Venereology*. 2007;21(6):852-858.

56. Scott JG, Cohen D, DiCicco-Bloom B, Miller WL, Stange KC, Crabtree BF. Understanding healing relationships in primary care. *Ann Fam Med*. 2008;6(4):315-322. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-48249146184&doi=10.1370%2fafm.860&partnerID=40&md5=91b88fe006021e1fcc585455519604a2. Accessed 30 August 2019. doi: 10.1370/afm.860.

57. Cassell EJ. Suffering, whole person care, and the goals of medicine. In: Hutchinson TA, ed. *Whole person care: A new paradigm for the 21st century.* New York, NY: Springer New York; 2011:9-22. https://doi.org/10.1007/978-1-4419-9440-0_2. 10.1007/978-1-4419-9440-0_2.

58. Horowitz A. Brittany maynard, death with dignity advocate, dies at 29. http://blog.diversitynursing.com/blog/topic/brittany-maynard. Updated 2014. Accessed Sep 15, 2019.

59. Maynard Brittany. My right to death with dignity at 29. http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/. Updated 2014. Accessed Sep 15, 2019.

60. Chemerinsky E. Washington v. glucksberg was tragically wrong. *Mich Law Rev*. 2008;106(8):1501. http://search.ebscohost.com/login.aspx?direct=true&db=bsu&AN=32768739&site=ehost-live&scope=site.

61. Luper S. The AMA on euthanasia and assisted suicide. *Perspect Biol Med*. 2016;59(2):189-197. https://www2.scopus.com/inward/record.uri?eid=2-s2.0-85012986014&doi=10.1353%2fpbm.2017.0003&partnerID=40&md5=b9eb9741021a59cc772809ba4793079f. Accessed 31 August 2019. doi: 10.1353/pbm.2017.0003.

62. Davis MP. Does palliative sedation always relieve symptoms? *J Palliat Med*. 2009;12(10):875-877.

63. Merriam-Webster Dictionary. Coach. . Updated 2019. Accessed Nov 29, 2019.

64. Fuks A. Healing, wounding, and the language of medicine. In: *Whole person care.* Springer; 2011:83-95.

65. Gallagher R. Palliative care: Learning to fall. *282 BCMD2B*. 2016:254.

66. Beauchamp TL, Childress JF. *Principles of biomedical ethics.* 7th ed. New York: Oxford University Press; 2013:459.

67. Sulmasy LS, Mueller PS. Ethics and the legalization of physician-assisted suicide: An american college of physicians position paper. *Ann Intern Med*. 2017;167(8):576-578.

APPENDIX I

Table 2: Summary of healing and some curing definitions found in the literature.

Citation	**Curing**	**Healing**
Mount (2003)		"Healing is at the core of the palliative care mandate to **support** optimal quality of life when medical science can no longer modify the natural history of disease ".
Liggins, J. (2018)		"Healing is necessary when there has been **a disruption of integrity and wholeness, experienced as suffering**". "Healing is conceptualized as **the intensely personal experience** at the heart of recovery […]"
Anderson (2017)		"Healing draws upon **psychosocial, spiritual, and biological aspect of living with illness** […]"
Szawarska (2017)	"Curing comes about as a result of **applying appropriate medical knowledge and practice to the medical problem** at hand".	"Healing comes about as a result of applying through prayer and laying on hands of a supernatural, **mysterious power that cannot be explained, taught, or rationally acquired**.
Hutchinson (2011) Chapter 1 Whole Person Care -Book-	"The goal of the patient in the **curing mode is survival**. This is not limited to physical survival but also extends to survival of all that the patient has learned to identify as himself including physical appearance, life style, relationships, and everything else that makes up a life. In other words, the goal is to **avoid change**". "In curing, the **patient depends on the expertise of the practitioner to control disease**". "In the curing mode, **the physician through his knowledge and expertise concerning disease clearly has more power**. That is why the patient consulted him in the first place". "In the curing mode, **the basis of knowledge is scientific, and this is expressed in the current requirement of evidence-base practice**".	"Healing comes from the **acceptance of change**. This acceptance allows the patient to grow to a new sense of himself as a person (perhaps with disease) with a **new experience of integrity and wholeness that is different than the old status quo**. " "In healing, **the patient begins to realize that it is his/her own resources that will finally lead to growth and that he/she is responsible for managing those resources**". "In the healing mode, **the power shifts toward the patient**. It is within the patient that healing will occur, and it is the patient who will make the healing journey. " "In the healing mode, this approach is not helpful. Since the **essence of the facilitation of healing is the relationship of one person to another**, the physician's role in healing has to depend on his particular gifts and characteristics as a person and on the particular gifts and characteristics of the patient. "
Feudtner (2005)		""[…]viewing healing as the attainment of a **holistically conceived, health-related goal be it the diminishment of physical or psychic pain, the acquisition of a sense of peace, or the repair of a cherished relationship** enables the prospect of healing to move quite confidently into the realm of end-of-life care".

Sternszus (2018)	"[…] curing **lend itself well to the language of biomedical science**. Indeed, medical students become quite adept at **classifying symptoms, making diagnosis, and identifying treatments that target the underlying pathophysiology** of the diagnoses they encounter".	
Dieppe (2015)		"In the medical sciences healing is **often construed as being about correcting pathological changes in the body, rather than enhancing wellbeing,** and the emphasis is often on acute changes and technological intervention".
Marshal (2008)		"Healing may be as simple as **the union of a wound for restoration of tissue integrity or as complex as the achievement of serenity and harmony among mind, body, and spirit**". "Healing begins **when suffering is acknowledged both by the person who suffers and by the one who offers care** ". "Healing is **not a passive experience of receiving care but an active endeavor from which the sufferer benefits from the support, guidance, and profound professional presence** a nurse may provide". "Ultimately, **healing is a private experience, unique to the individual, laden with personal meaning**".
Meza (2008)		"**Persons, not diseases, can be healed**" "Healing **exists within the doctor-patient relationship regardless of whether it is acknowledged**".
Scott (2008)		"Healing meant being cured when possible, reducing suffering when cure was not possible, and finding meaning beyond the illness experience".
Hutchinson (2011)		"Perhaps the **aim of medicine is not just to eradicate the suffering that can be eradicated but also to support patients in facing the suffering that cannot be eradicated**, and which they have been avoiding, with the **hope that they can experience a greater sense of integrity and wholeness**. Perhaps the real goal of medicine should be to support patients in their healing journey, to **help patients move toward a life with a greater sense of connection and meaning and a new relationship to wounding and suffering**".
Kenny		"[...]the healer as a facilitator of healing, of developing a sense of connection to sources of healing and becoming sensitive to the energy that comprises the courses of healing energy. It includes a deepening appreciation of the healee and their importance in creating the conditions in which healing takes place".
Eustache (2014)		"Patients in the current study described their hope and healing as a **dynamic experience leading toward a sense of acceptance, wholeness, and meaning in their lives**".

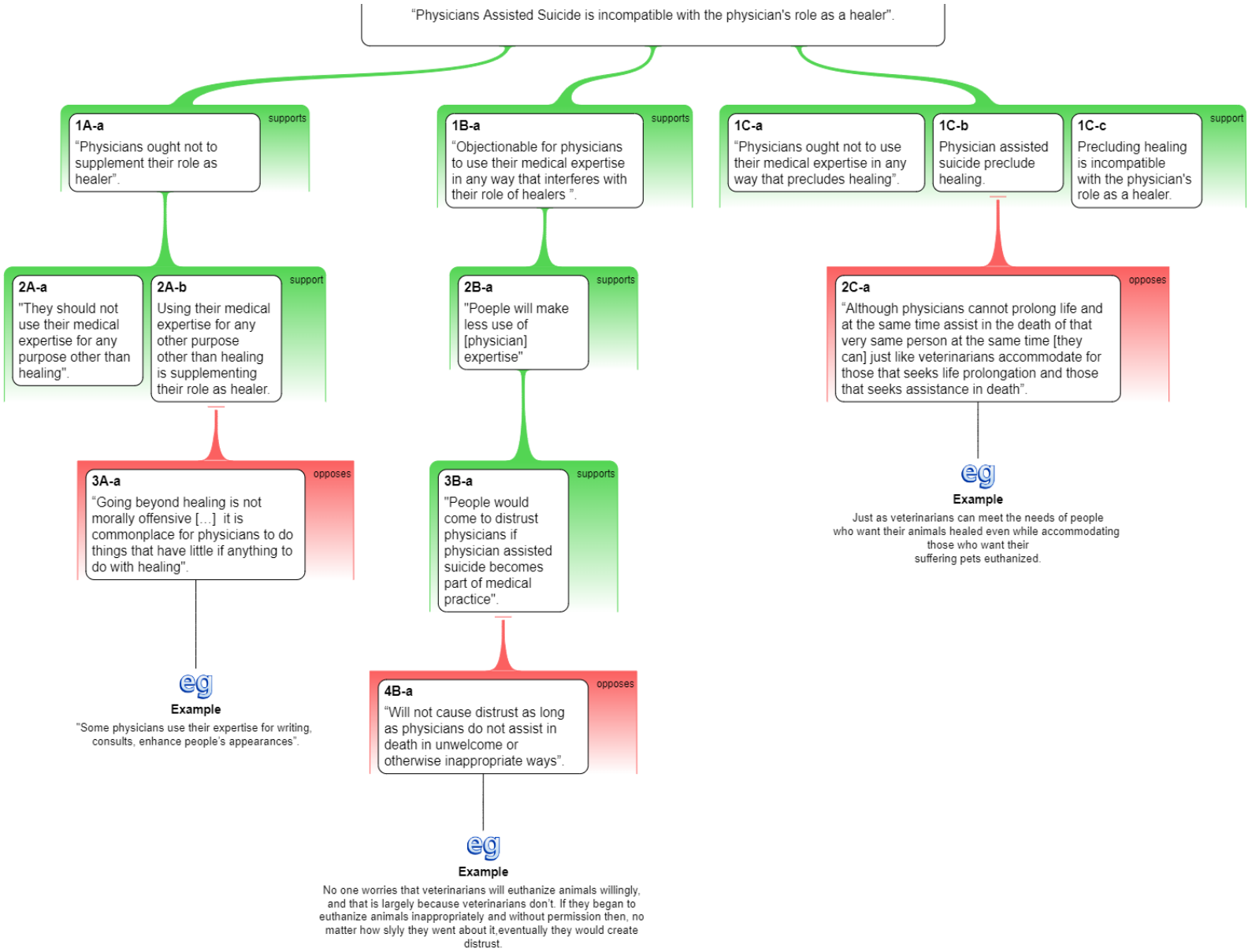
Glannon (2003)		"Healing **can occur along different dimensions and in varying degrees**. I will focus on the phenomenon of transcendence as one of these dimensions. Transcendence consists in shifting or relating our immediate experience of an event or state to a different type of experience that is beyond or otherwise distinct from that event or state. In life threatening diseases, **transcendence may be achieved by generating beliefs that shift one's awareness away from the future as a source of fear to an awareness of the timeless present**".
Firth, K (2015)	"[…]cure,[is] defined as the **eradication of physical symptoms of illness or disease**."	"[...]healing is a **holistic, transformative process of repair and recovery in mind, body, and spirit resulting in positive change, finding meaning, and movement towards self-realization of wholeness**, regardless of the presence or absence of disease. **Healing may or may not include cure**[...]"
Levine, J. (2017)		"A more expansive and coherent view of healing thus may contribute to health and medicine in multiple ways: through advancing our knowledge of human physiology and through fostering clinical, physical, and social environments that foster whole-person healing and healthier populations". "To some, **healing is an intervention, as in Therapeutic Touch or Reiki**. Healing is something done by healers—a therapeutic modality delivered by a practitioner to a client. To others, **healing is an outcome, such as recovery from illnes sorcuring of a disease**. As a result of treatment, whether conventional or alternative, we hope to experience a healing. To still others ,**healing is a process** [...]" "[...] Healing is usually asserted to be **multidimensional, expressing itself at various "levels"—physical, bioenergetic, emotional, mental, spiritual, interpersonal, societal, cosmic, etc**." "On the one hand**, biomedicine has a clear definition of healing**, and a narrow, circumscribed usage. The word "healing" **designates a concept primarily referencing the repair of a flesh or tissue wound.** Healing is thus considered **unidimensional- that is, conceptually limited to the repair of wounds** [...]"
Rhatz (2019)		"A number of people depicted healing as **having an awesome external source. Energy emanated from this source, radiating onto the individual and providing healing**". "The most common understanding of healing was that healing was **something each person could realize for themselves**: **achieving or maintaining a state of healing depended upon an inner".**
Glatsier, J.A. (2001)		"Healing is **a natural, active and multidimensional process that is individually expressed with common patterns**. Healing is **influenced by body-condition, personal attitudes and relationships**".

Gauthier (2002)		"The terminally ill individuals in this study have a common thread […] **maintaining relationship, a unique perception of hope, seeking forgiveness o, maintain the context of normality, having a sense of freedom, acceptance and maintain or rejoining in one's spiritual faith".**
Dobkin (2009)		"Healing is a process **involving movement toward an experience of integrity and wholeness in response to injury or disease**". "A consensus that healing **is both a personal and an interpersonal experience emerged**".
Orfano (2007)		"It all started with the priests, who were also magicians and healers, when human disease was mostly seen as a punishment for not keeping the rituals and for misbehavior or sins. At that early time, the process of healing was done by priests in temples as part of cults".
Egnew (2005)		"Thus, healing is **independent of illness, impairment, cure of disease, or death**". "In summary, healing was defined in terms of developing a sense of **personal wholeness that involves physical, mental, emotional, social and spiritual aspects of human experience**. Illness threatens the integrity of personhood, isolating the patient and engendering suffering. **Suffering is relieved by removal of the threat and restatement of the previous sense of personhood**".
Egnew (2009)		"Transcendence is categorically different from being cured of disease, and **cure does not equate to healing**. Transcendence of suffering through **holistic healing can occur regardless of cure, restoration of health, continued illness or impairment, or impending death**(**REF ID 260 Egnew2005)."** "The **physician-healer helps the patient discover opportunities for growth in the most dire of circumstances, and the ability to transcend suffering exists even in the presence of the most frightening of diseases**". "The physician-healer must know how to actively diagnose suffering and explore its origins if detected".
Egnew (2015)		"While not curable, many chronically and terminally ill patients can be healed, since **healing can occur despite illness, impairment, or death**. Therapists can augment healthcare efforts by supporting the process of healing, the transcendence of suffering". "A healer helps patients find a "why" to transcend their suffering".
Krajnik (2017)	*Synthesized Hutchinson (2011) Whole Person Care a new Paradigm for 21st century and Sajj (2017) Healing in Modern Medicine in a table*	*Synthesized Hutchinson (2011) Whole Person Care a new Paradigm for 21st century and Sajj (2017) Healing in Modern Medicine in a table*

Goprichanda (2016)	"[...] in medical technology, the biomedical scientist–physician has **become a curer rather than a healer**. The biomedical model lends itself to **an objective examination of the organs, systems and their functions, attributes diseases to the observations made and attempts cures that are specific to diseases**".	"Thus, the narrow biomedical concept of cure should be clearly distinguished from the **more holistic concept of healing, which encompasses the physical, mental, social and spiritua**l".
Sajj (2017)	"Physicians, trained as scientists, **focus on diagnosis, treatment, and prevention**. In doing so, cure and not care, has become the primary outcome."	"If physicians are dedicated to the task of healing patients, they must at least **attempt to understand how illness affects patients as spiritual individuals struggling with metaphysical questions**". "[…] **healing is a process with implications for search for meaning and purpose, not simply measurable outcomes**".

APPENDIX II

Figure 4: Argument Mapping Figure about (Luper, 2016) reasons and objection.



BIOGRAPHICAL STATEMENT

Vivian V. Altiery De Jesús was born in 1992 in San Juan, Puerto Rico.

High-School: Homeschool
Undergraduate: University of Puerto Rico-Río Piedras Campus | Biology-Cellular Molecular emphasis

Vivian is currently a fourth-year medical student at the University of Puerto Rico-School of Medicine. During her first three years of medical school she was actively involved in research. She completed the *Research Clinical Science Program (MCBI) Certificate* requirement. One of her research topics involved mitigating moral regression in first- and second-year medical students by creating Structured Ward Rounds. She also participated in several poster presentations, workshop and oral presentation. She will resume her fourth year in 2020.

In 2018, Vivian began her Master of Bioethics in the Berman Institute of Bioethics at the Johns Hopkins School of Public Health. She is also completing two certificates at Johns Hopkins School of Public Health: *Clinical Trial Certificate* and *Health and Human Rights Certificate*, both in the Epidemiologic department. Her ethical focus is in clinical and research ethics, with an emphasis in the end-of-life care and opioid epidemic. She participated over 120 hours of ethics related activities, such as shadowing different Johns Hopkins Hospital Ethics Committee, IRB committee, clinical ethics consults, among others. She wrote a 120-page manuscript of narrative medicine where she contemplates, analyze and shares her experience as a medical and master of bioethics student.

In 2019, Vivian became part of Student Assembly at the Johns Hopkins School of Public Health. Her role ranged from a Department at Large Member to Co-VP of Professional Development and Academic Honors. She was also involved in the school-wide Wellness and Quality of Life Committee. In 2020 she worked as teaching assistant in the *Research Ethics and Integrity: U.S. and International Issues* in the Health Policy and Management Department and as the Program Coordinator in ethics educations program of medical students and residency in the Berman Institute of Bioethics.